Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS 94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 490-1047 fax

Designated Doctor Examination Data Report
Extent of Injury, Disability, or Other Similar Issues

I. INJURED EMPLOYEE CLAIM INFORMATION

1. Employee's Name (Last, First, Middle)	2. Date of Injury (mm-dd-yyyy)	3. Employee's Social Security Number
4. Insurance Carrier's Name	5. Insurance Carrier Claim Number	6. TDI-DWC Claim Number

II. EXAMINATION INFORMATION

7. Designated Doctor's Name	8. Designated Doctor's Mailing Address (Street or PO Box, City State Zip)	
9. Designated Doctor's License Number	10. Designated Doctor's License Jurisdiction	11. Designated Doctor's License Type
12. Designated Doctor's Telephone Number ( )	13. Examination Location (Street, City State Zip)	14. Date and Time of Appointment
15. Does the claim involve medical benefits provided through a Certified Health Care Network? ☐ Yes ☐ No If yes, provide the name of the network.		
16. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? ☐ Yes ☐ No If yes, provide the name of the health care plan.		

III. DIAGNOSIS CODES FOR COMPENSABLE INJURIES

17. Refer to the DWC Form-032 you received for this examination and provide below all the injuries listed in Section VII, Box 43. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each compensable injury listed. You may assign up to four diagnosis codes for each compensable injury. Attach additional pages, if necessary.

Compensable Injury	For Data Purposes Only			
	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)				
2)				
3)				
4)				
5)				

IV. PURPOSE OF EXAMINATION

18. Issues considered during Designated Doctor's examination. Check all that apply and provide the requested information.

☐ **a) Extent of injury**

Refer to the DWC Form-032 you received for this examination and provide below all the injuries listed in Section VIII, Box 44C. Did you determine that the accident or incident giving rise to the compensable injury was a substantial factor in bringing about the additional claimed injuries/conditions, and without it, the additional injuries/conditions would not have occurred? Provide your answer below by checking Yes or No for each additional claimed injury/condition. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each additional claimed injury/condition. You may assign up to four diagnosis codes for each additional claimed injury/condition. Attach additional pages, if necessary.

Additional Claimed Injury / Condition	Yes	No	For Data Purposes Only			
			Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)	☐	☐				
2)	☐	☐				
3)	☐	☐				
4)	☐	☐				
5)	☐	☐				

☐ **b) Disability - Direct Result**

- Did you determine that the employee's inability to perform the pre-injury employment is a direct result of the compensable injury? ☐ Yes ☐ No

Refer to the DWC Form-032 you received for this examination and provide the following information as shown in Section VIII, Box 44D:

- Is the injured employee currently working? ☐ Yes ☐ No
- If yes, are current wages less than pre-injury wages? ☐ Yes ☐ No
- Provide the beginning and ending dates for the claimed periods of disability? If multiple periods, list all dates.

From to (mm/dd/yyyy)

☐ **c) Other Similar Issues**

Refer to the DWC Form-032 (Section VIII, Box 44G) you received for the examination and answer the applicable question below:

Did the claimed incident cause the claimed injury? ☐ Yes ☐ No

- OR -

Was the examination for another issue? ☐ Yes ☐ No

If yes, describe the issue listed in Box 44G:

V. REFERRALS / ADDITIONAL TESTING

Referral Health Care Provider Name	Provider License Number	Date of Service (mm/dd/yyyy)	Type of Testing						
			FCE */NCV*	EMG*	X-Ray	MRI*	CT-Scan*	Psychological Testing/ Evaluation	Other
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

*Functional Capacity Evaluation; Nerve Conduction Velocity; Electromyography; Magnetic Resonance Imaging; Computed Tomography Scan

VI. DESIGNATED DOCTOR'S SIGNATURE

20. Signature of Designated Doctor	21. Date of Signature

Filing Instructions:

- The DWC Form-068 must be filed when a designated doctor examination addresses issues of extent of injury, disability – direct result, or other similar issues. Do not file this form if the designated doctor examination only addressed issues of maximum medical improvement, impairment rating, and/or return to work.
- You must attach the narrative report required by 28 Texas Administrative Code §127.220, *Designated Doctor Narrative Reports*.
- The DWC Form-068, along with the narrative report, must be submitted as follows:
  - Send to the treating doctor, TDI-DWC, and the insurance carrier by facsimile or electronic transmission.
  - Send to the injured employee and the injured employee's representative (if any) by facsimile or electronic transmission if you have this information. Otherwise, you must send the reports by other verifiable means.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code §559.004).

For TDI-DWC Use Only